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PHYSIOS FOR WORK AND HEALTH

What is OH physiotherapy?

28th October 2024

Cameron Black Lasse Flosand

Aim and Objectives

- Define OH Physiotherapy

- Define the remit of OH Physiotherapy Practice:

A) As an *individual* and as part of an *OH team*.
B) In Terms of *Reactive* and *Preventative* (essential) competencies.

- Micro and Meso aspects of OH physiotherapy and wider work+health considerations

- Three different case studies to highlight how awesome we are!

What are OH Physiotherapists?

- Allied Health Professionals abiding standards set out by HCPC.
- Chartered Physiotherapists specializing in Occupational Health.
- ACPOHE is the Association of Chartered Physiotherapists in Occupational Health and Ergonomics.
- OH Physiotherapists are typically involved with the assessment, diagnosis, treatment/rehabilitation and management of employees that may present with a whole array of conditions and disability.

What is an OH Physiotherapist?

- Like Sports Physiotherapists, our job is to help keep staff in the 1st 11.

- Assessment, treatment, rehabilitation and case management of employees suffering from with MSDs, disabilities, Long Covid, Mental Health Problems, Chronic Pain, Pulmonary Problems, Neurological Conditions, Rheumatoid Arthritis, Cancer and more.

- As part of an OH Team : More of the same, but typically has defined boundaries depending on policy, team makeup and competencies within the team. Often involved with service development, depending on emerging trends in companies and societies.

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Rehabilitation and Reactive Scope

- Diagnostics and clinical reasoning
- Case Management and report writing.
- Clinical treatment and prescribing home exercise programs.
- Functional assessment rehabilitation – work specific.
- Functional Capacity Evaluation.
- Physiotherapy versus psychologist.
- Statistics – work-relatedness, referral areas, body parts.
- Team Work – Occupational Health Team, Health and Safety Team, HR, Engineering and the business as a whole.

Ergonomics and Preventative Scope

- Sharing statistics and relevant information to OH team / Client/ Company regarding work-related numbers, higher risk areas and more.
- Workplace and workstation assessments
- DSE, Manual Handling and Vehicle Assessments
- Larger Ergonomics Assessments
- Health Campaigns.
- Training in posture, movement, preventative exercise, manual handling, DSE, Vehicle setups and more.

Wider Scope of an Occupational Health Physio

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Introduction

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"**The good physician treats the disease**; the great physician treats the patient who has the disease." — Sir William Osler

"**Good surgeons** know how to operate, better ones when to operate, and the **best** when not to operate" — BMJ, 1999

OH ethics in applied context is described as 'two-master ethics or dual obligation' (Employer and employee) (Black et al, 2008)

Overview of existing UK workforce

2019-2023

55%

increase in sickness absence across the UK

Sick leave report
(Access People HR, 2024)

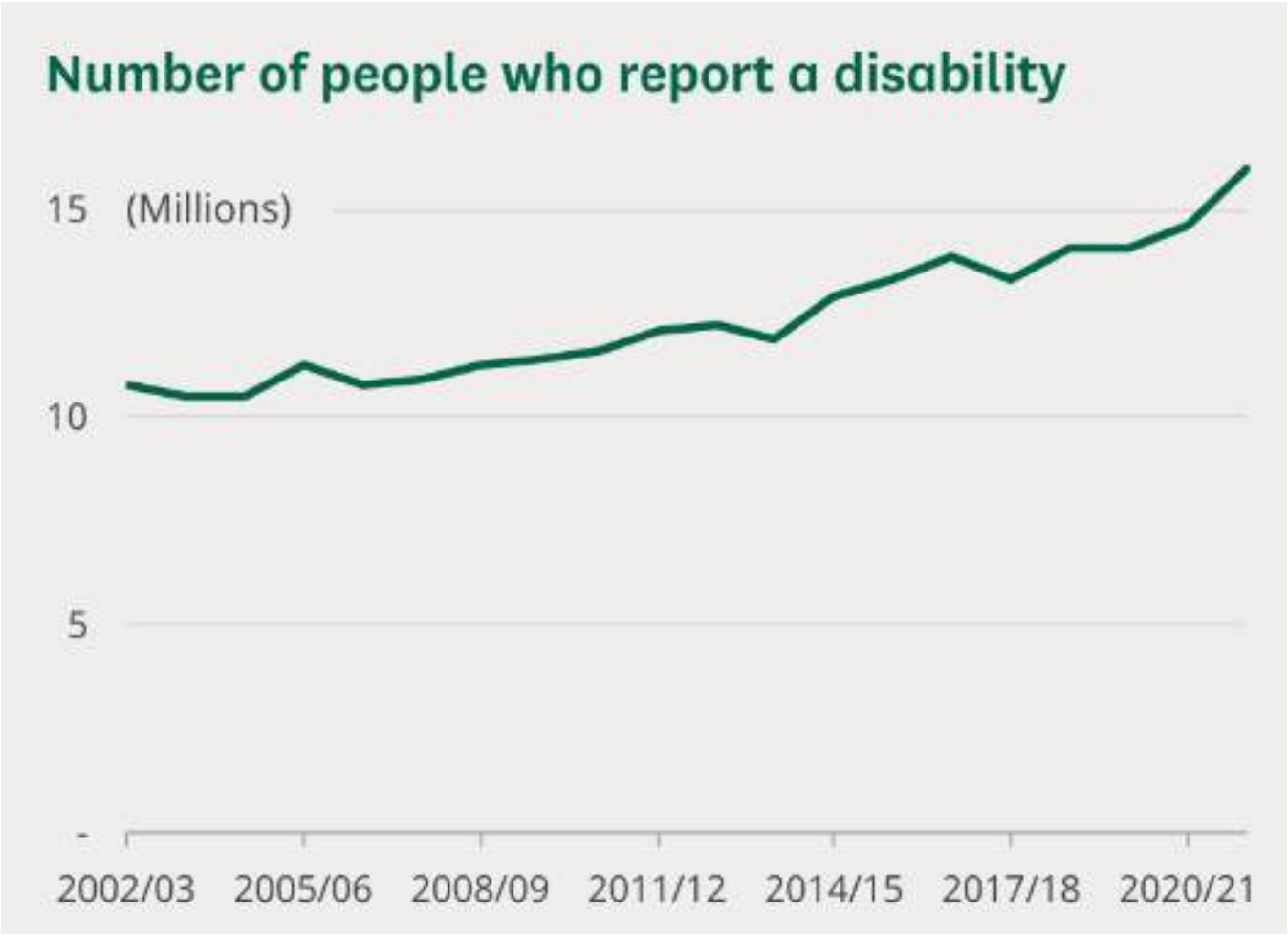
Average rate of employee absence:

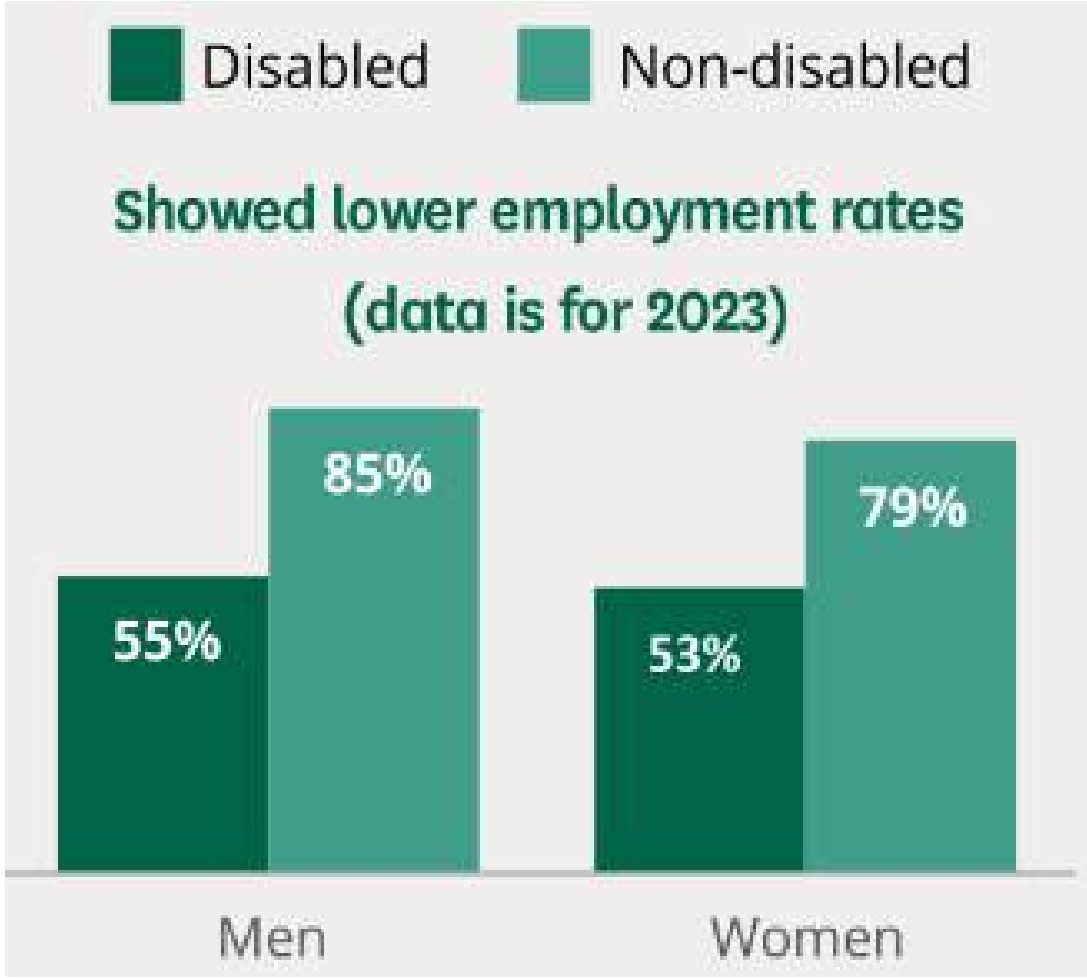
2019 - **5.8 days** per employee

2023 – **7.8 days** per employee

Health & wellbeing at work report (CIPD, 2023)

Overview of existing UK workforce challenge





24% of the UK population

DWP & ONS (2023)

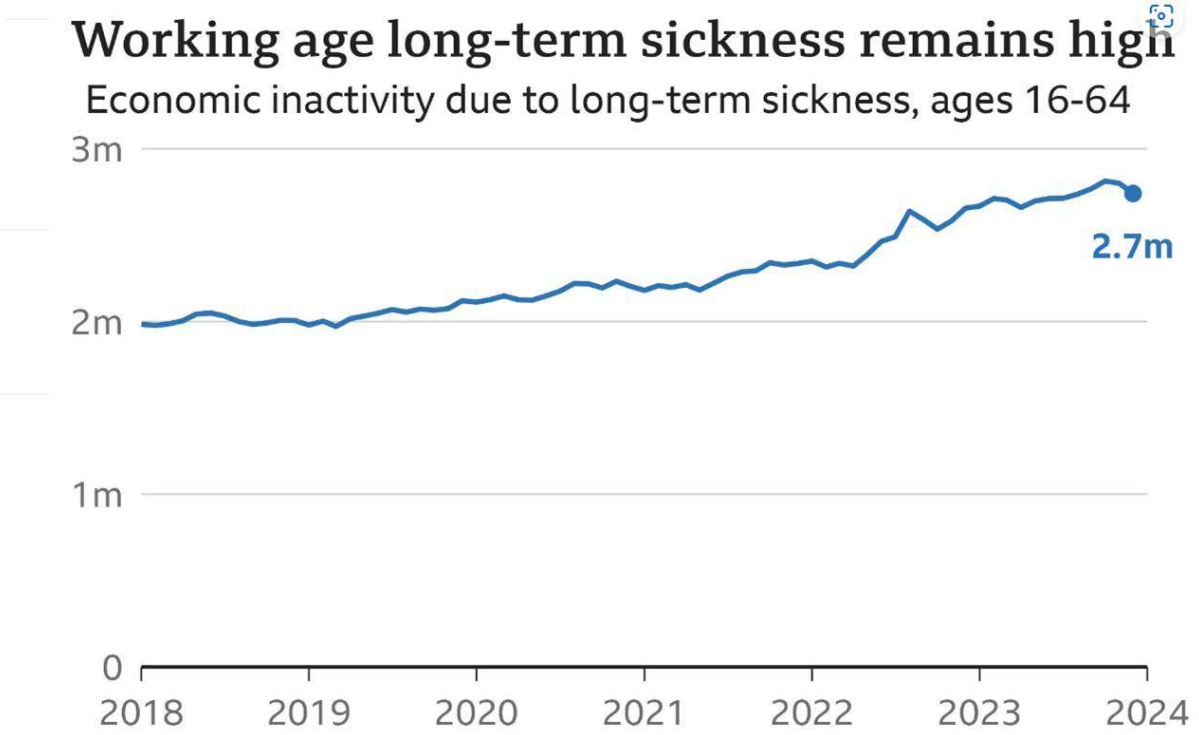
Introduction

Supporting people **back to work** is not just about the economy – substantial personal and social benefits

The benefits come from ***good jobs*** – safe and acceptable

ONS, 2024

9.2 million people aged between 16 and 64 in the UK are not in work nor looking for a job. The total figure is more than 700,000 higher than before the coronavirus pandemic.



Introduction

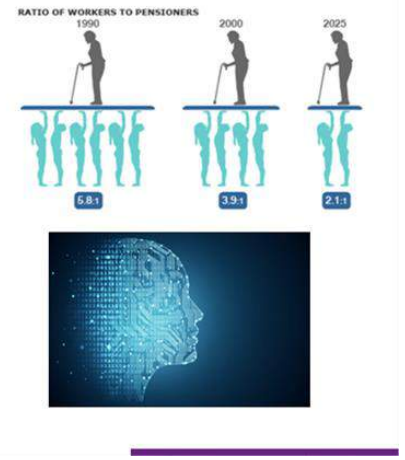
Helping millions of people **RTW** is important

Helping people **stay in work** with the below context is of = importance

<u>economic inactivity</u>

7.8 days per person off work per year

Due to stress and MSK



Smart physiotherapy is required

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New circumstanc

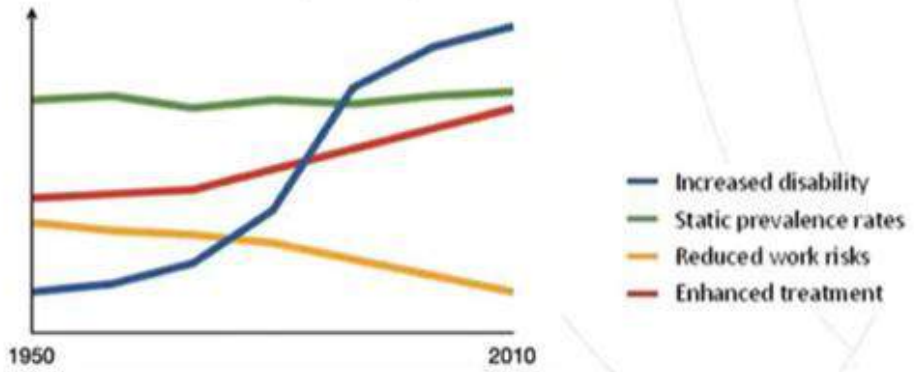
The current appr disability

RTW requires ac atient in front of you

Real life

A 'health and safety' approach to health problems can be...

Counterproductive!



Burton, K et al.

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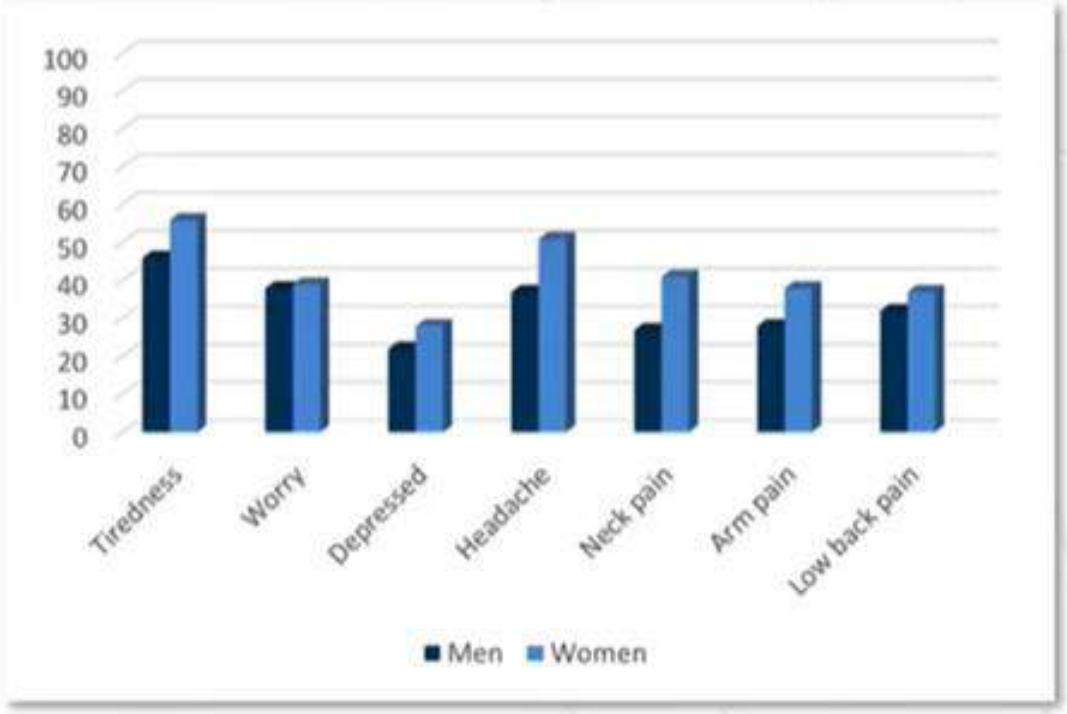
Common health problems (CHPs)

...are common* -



75% of respondents reported at least 1 symptom in the preceding 30 day period
>50% reported at least 2 symptoms or more

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The slide to disaster

social constructs + separated systems → obstacles to recovery

- Before health problem — Person
- At onset of health problem — Person
- At time of seeking healthcare — Patient
- If signed off work — Beneficiary
- On failure to recover/participate — Dispossessed

adapted from Hadler

Prof Kim Burton 2020

Challenges

42% of employed people had problems at work

Struggle with the **physical components** of their job

Social pressure to maintain employment and return to work

Guilt towards other colleagues and managers

Assistance needed to modify the workplace

Insufficient advice or support in relation to work practices and safe transition of return to work

HCPs more likely to advise **<u>work avoidance</u>** rather than strategies to help maintain employment

Challenges

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Individuals often struggle to maintain their work ability

They often do not have a more serious health condition or more severe injury

-it is less what has happened to them and more why they don't recover as expected

-its because they face obstacles to recovery and participation (BPS is required)

What do we say?

What do we say?

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The solution – Sickness Absence

it is *what* HCPs say during such conversations, and not simply raising or initiating the conversation, that likely has an important influence on patients' work outcomes.

HCPs largely view recommendations to discuss work as conflicting with their own clinical judgement

1. What do you think has caused your problem?
2. What do you expect is going to happen?
3. How are you coping with things?
4. Is it getting you down?
5. When do you think you'll get back to work?
6. What can be done at work to help?

Challenges

Fit Note

Cameron Black

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1 Introduction

94% of the 8.8 million Fit Notes completed by GPs in 2020 advised that the patient was 'not fit for work'.[1]

95% of the time, Fit Notes used to certify patients off sick had no suggestions about adjustments or advice to keep them in work.[1]

The problem with the old system was that it was not working, with Fit Notes often focusing on the 'not fit for work' option, rather than the 'may be fit for work' section.

Most of the UK population's healthcare needs are addressed within primary care settings, and it should be a welcome step for patients to be considered for a Fit Note by their treating healthcare professional when presenting with a common health problem.

As of 1st July 2022, physiotherapists, pharmacists, occupational therapists and nurses in a range of healthcare settings can certify Fit Notes.[2] This is a

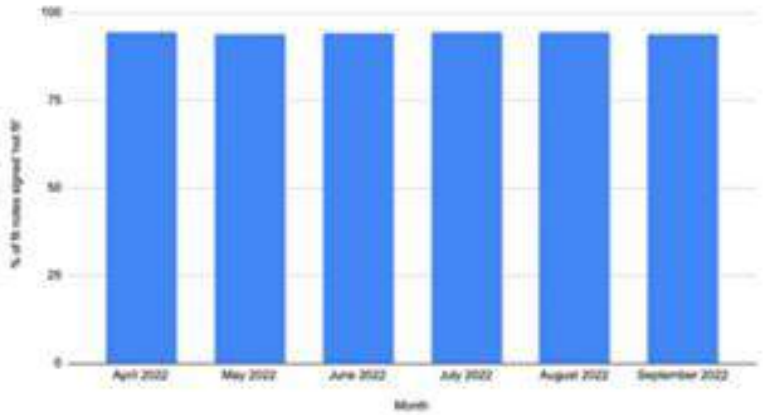


Figure 1. Percentage of Fit Notes signed not fit for work issued in general practice in England

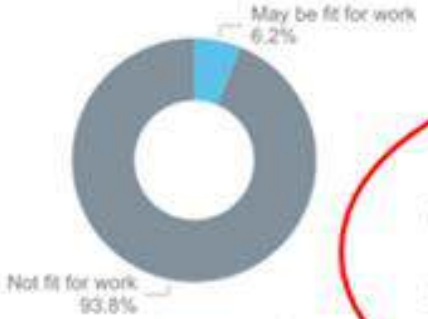


Figure 2. Fit Note decision after consultation

Figure 3. Chance of returning to work once off sick

Smart solutions

robust evidence to suggest that a **lack of work-focused healthcare** (i.e. a failure by healthcare professionals to address work issues within the clinical encounter) is an obstacle to **work participation**

Gatekeeper vs Advocate

Can help or hinder!

"*People who return to work early, even in a limited capacity, have the fastest recovery rates.*"

"Going to work encourages activity, which helps your recovery."

"Work is an important part of our lives and provides us with a daily routine and self-esteem."

"An early return to the workplace is a very important step in your recovery process."

"In the initial stages of your return to work, it's important to pace yourself and take regular breaks e.g. for rest and movement"

*"What three things about your health problem and your work are affecting your **work ability** – in other words, what's making it difficult to stay at work (or get back to work?)"*

Managing Sickness Absence

Healthcare Concepts

01 **Public Health Campaign**

work is important for health and wellbeing, working can mean faster recovery, and it is 'good to talk about work'.

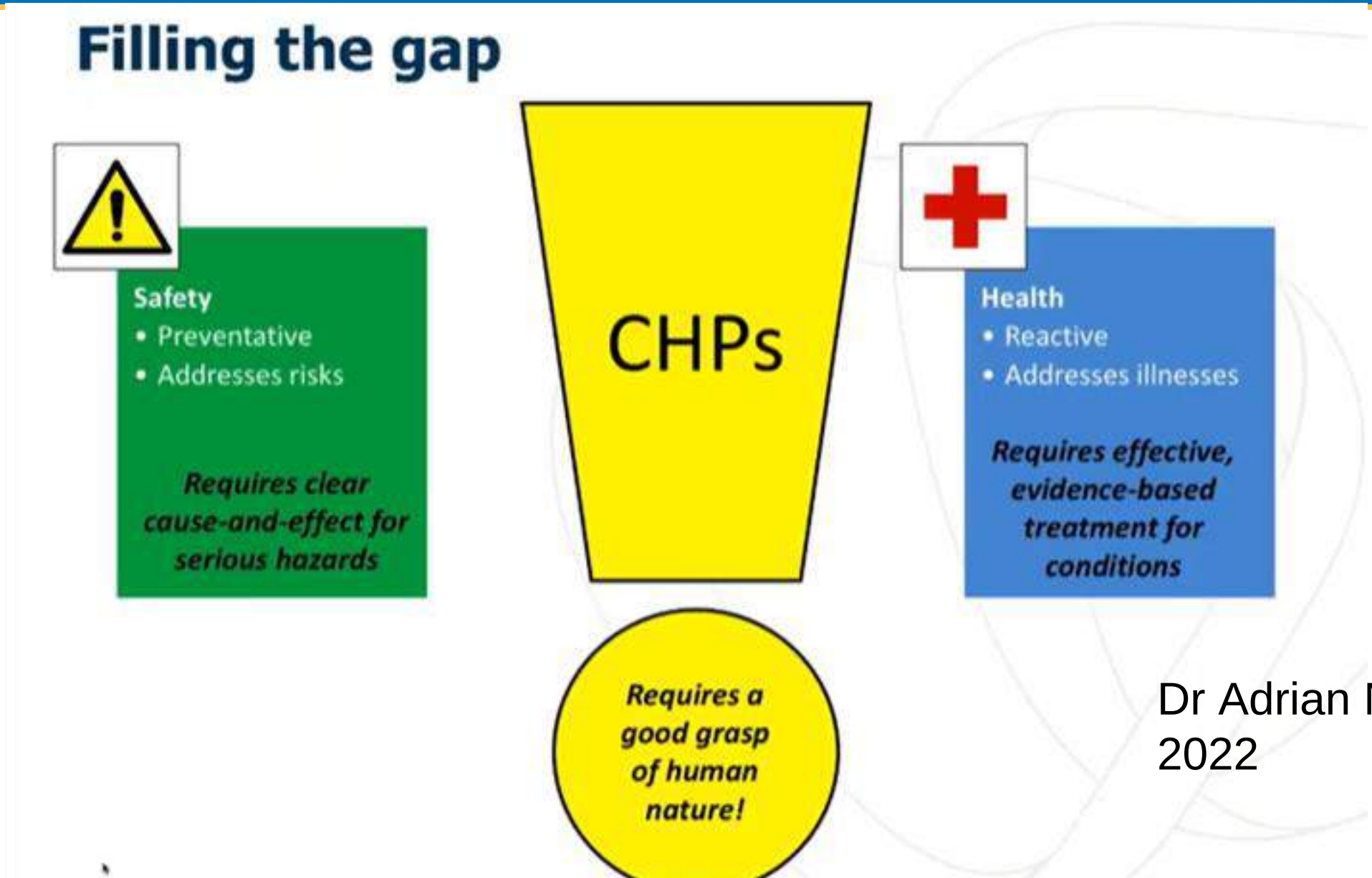
02 **Work Convos**

HCPs need sufficient knowledge, along with tools, guidance, and checklists, to respond to questions and initiate actions

03 **Integrated practice**

generic competencies in the undergraduate curriculum, and should be managed by local champions to help take learning into everyday practice. H&W champions

Smart solutions

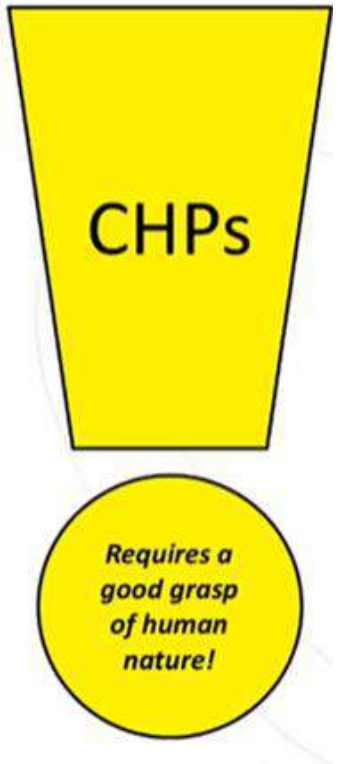


Dr Adrian Massey, 2022

Summary

Healthcare has a key role in common health conditions but **treatment** by itself has little impact on work outcomes

Treating in isolation can remove patients from the workplace and act as a barrier to successful rehab



Dr Adrian Massey, OHP, 2021
& Prof. Kim Burton, personal communication 2022

Temporary provision of **modified work and adjustments** is effective and cost-effective

It reduces **work days lost and the no of injured workers who go on to develop chronic disability**

Work focussed healthcare and **accommodating workplaces** are needed but this is a classic systems issue

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Case Study 1

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- 42-year-old male absent from work for 2 days following gradual onset and worsening of Lower Back Pain over the course of 2 months.
- Referred by manager, asking for information around diagnosis, return-to-work date and work adjustments.
- Symptoms moderate to severe, struggled with job prior to absence.
- Recent change in job role within the factory, change in management and change of work colleagues.
- Employee reports heavy lifting and repetitive bending due to faulty lifting equipment.
- Clinical reasoning indicates posterior soft tissue injury to Lx spine, flexion reproduces symptoms, extension reducing symptoms. Loss of both flexion and extension. Positive prone SLR and palpation of both lumbar erector spinae musculature. Normal mobility on PA L5 - L1, mild reproduction of symptoms only. No red flags, no neurological symptoms. Fit and healthy, gym goer.
- Employee voices conflict with Team Leader.

Case Study 1

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Discussion

Case Study 1. What are your thoughts to barriers to return to work? How would you case manage this employee? (padlet.com)

Case Study 2

Dr Stevens, a 42-year-old ophthalmologist, developed chronic neck pain (approx.16 weeks on referral to OH) due to prolonged periods spent in a forward-leaning position while examining patients and performing diagnostic eye procedures. It caused headaches and affected her productivity and job satisfaction.

Dr Stevens was concerned that physical activity might exacerbate her neck pain.

Her pain intensity fluctuated based on her daily workload, making it challenging to adhere consistently to exercises and HCP reviews.

Also fear of appearing "weak" or needing “special treatment”

Case Study 2 (padlet.com)

The issue

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Organisational + Individual risk factors

MSK conditions - Risk

Table 1 Mechanical and psychosocial risk factors for work-associated musculoskeletal disorders.

Mechanical	• Heavy lifting
	• Pushing, pulling and rotating heavy loads
	• Working in awkward postures or positions (e.g. working with arms raised above shoulder height)
	• Prolonged static postures
	• Repetitive movements of the limbs and/or joints
	• Environmental, e.g. poorly designed/constructed equipment including: clinical devices; anaesthesia workstations and chairs; badly placed monitors, keyboards and other IT equipment; poor theatre layout; manually operated theatre tables and trolleys
Psychosocial	• Working under pressure and/or to tight deadlines
	• Lacking control of workload and work tasks
	• Having poor support from colleagues and/or managers
	• Depression
	• Poor job satisfaction
	• Perceived lack of reward for effort expended
	• Low self-efficacy*

*Self-efficacy: an individual's belief in having the required capabilities to achieve a goal [2]

Table 1 - From Guidelines: Better musculoskeletal health for Anaesthetists [1]

Principles

Decrease tissue load

Increase tissues strength and resistance

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MSK Pain in Ophthalmology: The Problem

In a 2015 UK study 62.4% of 518 consultant ophthalmologists reported back and/or neck pain. Of those surveyed, over 30% reported pain while operating or using a slit-lamp.

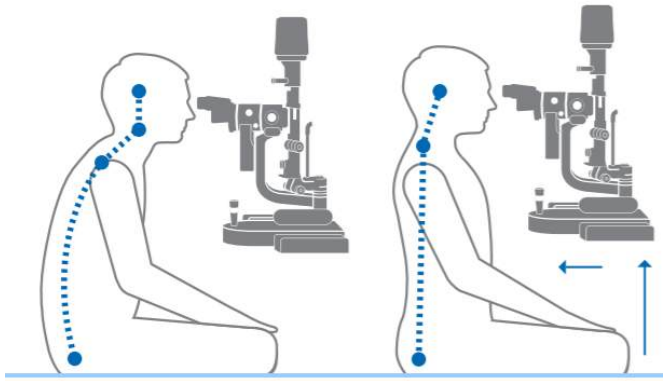
MSK pain is a major contributing factor in reducing Ophthalmologists' productivity and increasing the risk of leaving the healthcare workforce.

The Ophthalmologist's work involves a combination of:

- **visually demanding work (fine motor control and close visual focus),**
- **repetitive tasks within a high-volume clinic,**
- **prolonged awkward postures and head/neck positions while working,**
- **frequent pull/pushing/rotation of slit lamp tables to allow patient entry/exit from clinical area.**

Considerations for Clinicians

- Head, neck, torso should ideally be aligned in a neutral posture, without the neck in a forward posture/poking chin.



- Adjust your chair height so that your hips and knees are at 90 degrees, then bring the height of the slit lamp table up or down, and the slit lamp itself forwards or backwards, so that you can view through the eye pieces without hunching your neck, shoulders or back.

- When rotating the slit lamp table for the patient to enter or exit the area, try to do this smoothly with one hand on each side of the table, so that that load is shared evenly across both hands, rather than through one wrist only. If the table castors do not glide easily, please raise this with your line manager.

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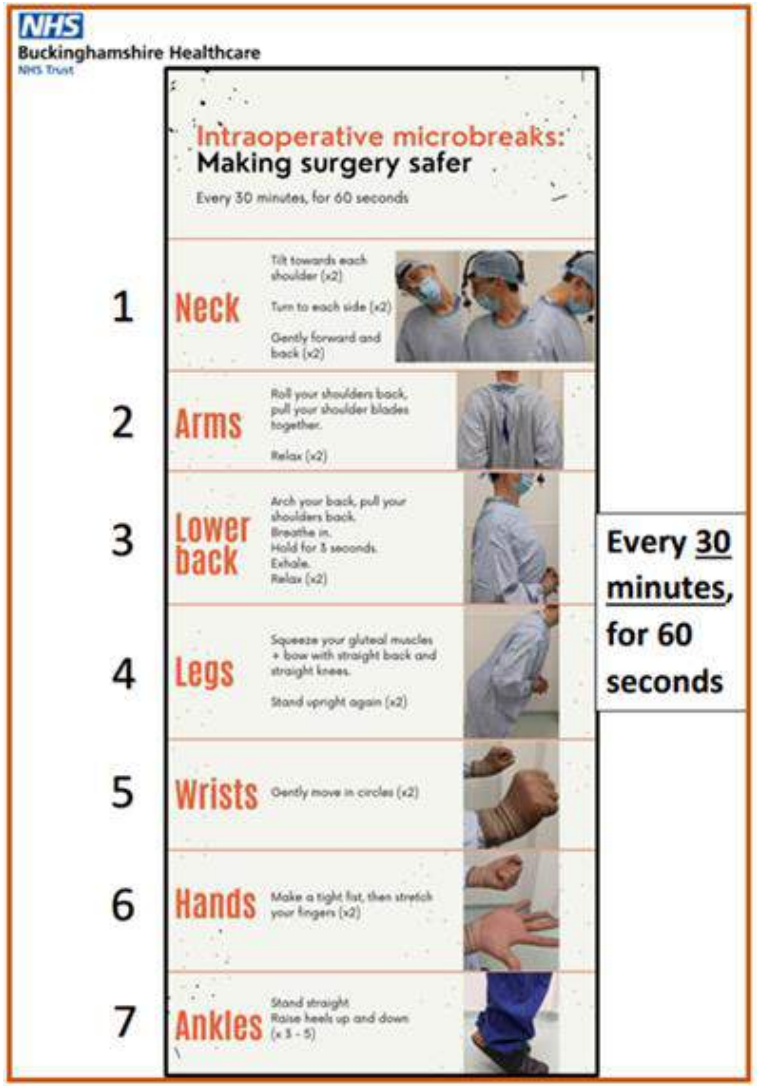
Considerations for Clinicians

- Once your position has been optimised, help the patient to adjust their seat to bring themselves into suitable position for the assessment. This [may] mean that the patient is a little uncomfortable for 2-5 minutes, once, instead of the clinician being in that awkward position over 30-40 times every day.

- If you regularly rest your elbow onto the table for stability of your hand, consider using elbow rests for a cushioned surface.

Slit lamp assessment - Elbow rests in place [6]

Relievers and preventers



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Case Study 3

Devi, 61-year old cleaner presented with ankle fracture, tripping over garden furniture and managed conservatively. C/o Mid and LBP 12 weeks post injury. >3 units of alcohol per day, previous smoker, post-menopausal. H/o low trauma wrist injury 1 year ago.

BMI of ≤ 19 kg/m2. Treated conservatively for 8 weeks within MSK secondary care. Referred to OH for opinion on symptoms and work ability.

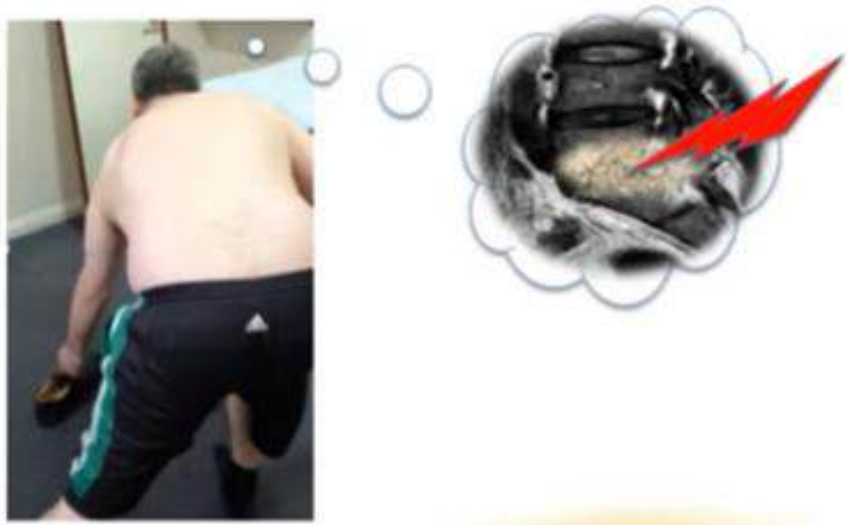
Case Study 3 - Outcome

“These broken bones break lives – the UK’s fourth biggest cause of disability and early death”

Key Points:

- Resistance training machines should be avoided in individuals at high risk of vertebral fracture unless there is certainty that they can be used and adjusted with proper form.[19]
- Avoid unstable surfaces.[3]
- Begin at a lower intensity. Exert care to prevent falls.[3]
- Strength and resistance exercises are recommended as well as:[17]
  - Weight bearing aerobic exercises
  - Multicomponent exercises
  - Whole body vibration
- Spine movements should minimize repeated/sustained, weighted, end-range, rapid/forceful or combined flexion/rotation/side bending.[18,19]
- Instruct the patient to focus on form and good alignment over intensity. Emphasize neutral spine without twisting the spine. Training in technique and supervision is essential.[19]
- Add spine-sparing strategies to decrease spine loads.[19]
- Patients are recommended to perform 5-10 minutes of posture/back extensor training daily:[19]
  - Basic: Lie face up on firm surface, knees bent, feet flat. Use pillow only if head does not reach the floor.
  - Progressions:
    - Lying with gentle head press; without changing chin position, perform 3-5 second "holds."
    - Erector spinae activation in standing.
- Avoid positions/exercises that increase compressive loads such as:[20]
  - Sit ups
  - Full neck rotations
  - Forced spinal rotation with flexion
  - Flexion exercises (especially forced or extreme forward flexion)
  - Lifting both legs (compresses the lumbar spine)
  - High impact exercises
  - Excessive loading of the spine
  - Sudden jerky movements
  - Weighted lifting with arms away from the body
- Intensity: High to very high (80–85% 1RM; ≥16 on Borg 6–20 point RPE scale or 'Very hard').[22]
- Frequency: 2 or more times per week.[22]
- Sets/Repetitions: 2–3 sets of 8-12 repetitions.[22, 28]

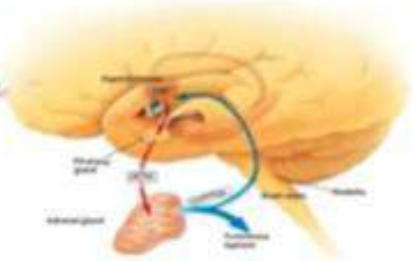
Fear, pain and physiological responses



Fear

Pain anxiety

'fight - flight response'



HPA axis

Glombiewski et al PAIN 2015
Rabey et al Clin J Pain 2016

Contemporary understanding of pain?

Specific to perceived threat

- posture, movement, activity, social setting, work

Avoidance of a threatening activity

Persistence of threatening activity with muscle guarding

Hasenbring et al Pain 2010

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Lifestyle factors and LBP

Sedentary behaviour
Activity avoidance

Obesity

Sleep deficits > 6 hrs

Increased circulating cytokines (inflammatory environment)
Lower pain thresholds
Reduced endogenous pain inhibition
Immune system changes
Structure health

Auvinen ESJ 2010
Heffner EJP 2011
Egger Obesity 2010

The changing role of OH

Old

Transactional
Disempowering
Stereotypical
Largely employee-facing
Inefficient

New

Consultative
Empowering
Orchestral
Largely manager-facing
Efficient focus of resource

Summary

Principles and Process

- PRINCIPLES
  - Work is an important health outcome
  - Physical and mental symptoms common
  - Treatment not always needed
  - Most people can stay at work
  - Some will struggle with work tasks or environment
    - absence appropriate if work intolerable
  - Early return to work beneficial
    - avoids disability

- PROCESS
  - Accurate consistent information/advice
  - Good jobs
  - Use stepped care principles
  - Work focused healthcare
    - don't overmedicalize
  - Workplace action
    - identify obstacles to work ability
    - RTW Plan- single most effective element
    - *temporary* job modifications

Conclusion

“A jack of all trades is a master of none”

+ Specialist backgrounds

? MSK ?Neuro ? Trauma ? Ortho ? Resp

”but often times better than a master of one”

Being a generalist is needed for OH practice!

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Thank you

28th October 2024

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